		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033340

Facility Name: AVENUE CARE CENTER

Address: 4505 S. DREXEL (Number) CHICAGO (City) 60603 (Zip Code)

County: COOK

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-3558590

Date of Initial License for Current Owners: 02/01/88

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHERWIN RAY
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,575	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,575	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,095	3,095	8
9	SNF/PED					9
10	ICF	48,102	682	72	48,856	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,102	682	3,167	51,951	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.83%

D. How many bed-hold days during this year were paid by Public Aid?
1,108 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 21 and days of care provided 3,095

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	141,928	20,162	12,907	174,997		174,997	1,967	176,964			1
2	Food Purchase		161,623		161,623	(15,275)	146,348	(736)	145,612			2
3	Housekeeping	116,919	27,533		144,452		144,452		144,452			3
4	Laundry	48,958	16,336		65,294		65,294		65,294			4
5	Heat and Other Utilities			109,614	109,614		109,614	439	110,053			5
6	Maintenance	36,819	28,597	30,261	95,677		95,677	11,807	107,484			6
7	Other (specify):*			10,289	10,289		10,289		10,289			7
8	**TOTAL General Services**	344,624	254,251	163,071	761,946	(15,275)	746,671	13,477	760,148			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	1,279,055	55,956	128,085	1,463,096		1,463,096	(91,024)	1,372,072			10
10a	Therapy	80,711	1,491	39,897	122,099		122,099	4,358	126,457			10a
11	Activities	83,941	7,903	1,875	93,719		93,719		93,719			11
12	Social Services	131,128		3,806	134,934		134,934		134,934			12
13	Nurse Aide Training											13
14	Program Transportation			145	145		145		145			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,574,835	65,350	179,308	1,819,493		1,819,493	(86,666)	1,732,827			16
	C. General Administration											
17	Administrative	131,560		330,000	461,560		461,560	(274,005)	187,555			17
18	Directors Fees											18
19	Professional Services			277,060	277,060		277,060	(222,110)	54,950			19
20	Dues, Fees, Subscriptions & Promotions			28,970	28,970		28,970	(267)	28,703			20
21	Clerical & General Office Expenses	22,277	11,195	137,845	171,317		171,317	(22,561)	148,756			21
22	Employee Benefits & Payroll Taxes			324,895	324,895	15,275	340,170		340,170			22
23	Inservice Training & Education			2,310	2,310		2,310	1,060	3,370			23
24	Travel and Seminar							425	425			24
25	Other Admin. Staff Transportation			204	204		204	2,995	3,199			25
26	Insurance-Prop.Liab.Malpractice			123,561	123,561		123,561	4,506	128,067			26
27	Other (specify):*							41,615	41,615			27
28	**TOTAL General Administration**	153,837	11,195	1,224,845	1,389,877	15,275	1,405,152	(468,342)	936,810			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,073,296	330,796	1,567,224	3,971,316		3,971,316	(541,531)	3,429,785			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number AVENUE CARE CENTER #0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			45,760	45,760		45,760	115,882	161,642			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(99,612)	(99,612)		(99,612)	438,831	339,219			32
33	Real Estate Taxes			170,622	170,622		170,622		170,622			33
34	Rent-Facility & Grounds			550,918	550,918		550,918	(541,991)	8,927			34
35	Rent-Equipment & Vehicles			35,260	35,260		35,260	(3,409)	31,851			35
36	Other (specify):*											36
37	**TOTAL Ownership**			702,948	702,948		702,948	9,313	712,261			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		52,814	107,871	160,685		160,685	(15,166)	145,519			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,863	84,863		84,863		84,863			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		52,814	192,734	245,548		245,548	(15,166)	230,382			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,073,296	383,610	2,462,906	4,919,812		4,919,812	(547,384)	4,372,428			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,936)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(736)	2		13
14	Non-Care Related Interest	(97)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(16,499)	21		18
19	Entertainment		20		19
20	Contributions	(400)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(1,352)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,129)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (29,149)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(518,235)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (518,235)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (547,384)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

AVENUE CARE CENTER

ID# 0033340

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AVENUE CARE CENTER # 0033340 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	1,967	0	0	0	0	0	0	0	0	0	1,967	1
2	Food Purchase	(736)	0	0	0	0	0	0	0	0	0	0	(736)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	439	0	0	0	0	0	0	0	0	0	439	5
6	Maintenance	0	11,807	0	0	0	0	0	0	0	0	0	11,807	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(736)	14,213	0	0	0	0	0	0	0	0	0	13,477	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(125,000)	33,976	0	0	0	0	0	0	0	0	(91,024)	10
10a	Therapy	0	0	9,304	(4,946)	0	0	0	0	0	0	0	4,358	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(125,000)	43,280	(4,946)	0	0	0	0	0	0	0	(86,666)	16
	C. General Administration													
17	Administrative	0	(330,000)	55,995	0	0	0	0	0	0	0	0	(274,005)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(230,000)	7,890	0	0	0	0	0	0	0	0	(222,110)	19
20	Fees, Subscriptions & Promotions	(2,881)	0	2,614	0	0	0	0	0	0	0	0	(267)	20
21	Clerical & General Office Expenses	(16,499)	(93,000)	86,938	0	0	0	0	0	0	0	0	(22,561)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,060	0	0	0	0	0	0	0	0	1,060	23
24	Travel and Seminar	0	0	425	0	0	0	0	0	0	0	0	425	24
25	Other Admin. Staff Transportation	0	0	2,995	0	0	0	0	0	0	0	0	2,995	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,506	0	0	0	0	0	0	0	0	4,506	26
27	Other (specify):*	0	0	41,615	0	0	0	0	0	0	0	0	41,615	27
28	**TOTAL General Administration**	(19,380)	(653,000)	204,038	0	0	0	0	0	0	0	0	(468,342)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(20,116)	(763,787)	247,318	(4,946)	0	0	0	0	0	0	0	(541,531)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number AVENUE CARE CENTER **#** 0033340 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(8,936)	0	124,818	0	0	0	0	0	0	0	0	115,882	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(97)	0	438,928	0	0	0	0	0	0	0	0	438,831	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(541,991)	0	0	0	0	0	0	0	0	(541,991)	34
35	Rent-Equipment & Vehicles	0	(11,679)	8,270	0	0	0	0	0	0	0	0	(3,409)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,033)	(11,679)	30,025	0	0	0	0	0	0	0	0	9,313	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(15,166)	0	0	0	0	0	0	0	(15,166)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	(15,166)	0	0	0	0	0	0	0	(15,166)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(29,149)	(775,466)	277,343	(20,112)	0	0	0	0	0	0	0	(547,384)	45

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE				CAREPLUS MGMT.	NILES	MGMT/CLERICAL
				CAREPLUS REHAB	NILES	THERAPY
				AVENUE ASSOC.		
				LLC	NILES	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	DIETARY CONSULT. FEES	$ 6,600	CAREPLUS MANAGEMENT, INC.		$	$ (6,600)	1
2	V	10	MEDICAL RECORDS FEES	50,000	" "			(50,000)	2
3	V	10	MENTAL HLTH CONSULT. FEES	25,000	" "			(25,000)	3
4	V	10	PROGRAM CONSULT. FEES	50,000	" "			(50,000)	4
5	V	17	MANAGEMENT FEES	330,000	" "			(330,000)	5
6	V	19	ADMIN. CONSULT. FEES	218,000	" "			(218,000)	6
7	V	19	DATA PROCESS FEES	12,000	" "			(12,000)	7
8	V	21	CLERICAL FEES	93,000	" "			(93,000)	8
9	V	35	COMPUTER LEASE	11,679	" "			(11,679)	9
10	V	1	DIETARY SALARIES		" "		8,567	8,567	10
11	V	5	ELECTRICITY		" "		439	439	11
12	V	6	MAINT & REPAIRS		" "		1,042	1,042	12
13	V	6	MAINTENANCE SALARIES		" "		10,765	10,765	13
14	Total			$ 796,279			$ 20,813	$ * (775,466)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 550,918	AVENUE ASSOCIATES, LLC		$	$ (550,918)	15
16	V	30	SL DEPRECIATION				110,657	110,657	16
17	V	32	INTEREST				404,184	404,184	17
18	V								18
19	V								19
20	V	10	NURSING SALARIES		CAREPLUS MGMT, INC.		33,976	33,976	20
21	V	10a	THERAPY SUPPLIES SERVICE		" "		302	302	21
22	V	10a	THERAPY SALARIES		" "		9,002	9,002	22
23	V	17	ADMIN. SALARIES		" "		55,995	55,995	23
24	V	19	PROFESSIONAL FEES		" "		7,890	7,890	24
25	V	20	ADVERTISING		" "		2,614	2,614	25
26	V	21	TOTAL OFFICE		" "		21,806	21,806	26
27	V	21	CLERICAL SALARIES		" "		65,132	65,132	27
28	V	23	SEMINARS		" "		1,060	1,060	28
29	V	24	TRAVEL		" "		425	425	29
30	V	25	TRANSPORTATION		" "		2,995	2,995	30
31	V	26	INSURANCE		" "		4,506	4,506	31
32	V	27	EMPLOYEE BENEFITS		" "		41,615	41,615	32
33	V	30	DEPRECIATION (SL)		" "		14,161	14,161	33
34	V	32	INTEREST		" "		34,744	34,744	34
35	V	34	OFFICE RENT		" "		8,927	8,927	35
36	V	35	EQUIPMENT RENT		" "		8,270	8,270	36
37	V								37
38	V								38
39	Total			$ 550,918			$ 828,261	$ * 277,343	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger		4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item		Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		10A	THERAPY SERVICES	$	36,341	CAREPLUS REHABILITATIVE SERVICES		$ 31,395	$ (4,946)	15
16	V		39	ANCILLARY THERAPY		111,425			96,259	(15,166)	16
17	V										17
18	V										18
19	V										19
20	V										20
21	V										21
22	V										22
23	V										23
24	V										24
25	V										25
26	V										26
27	V										27
28	V										28
29	V										29
30	V										30
31	V										31
32	V										32
33	V										33
34	V										34
35	V										35
36	V										36
37	V										37
38	V										38
39	Total				$	147,766			$ 127,654	$ * (20,112)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN I. RAY	PRESIDENT	ADMINISTRAT.	19.70	SEE ATTACHED	5.4	8.97	SALARY	16,577	17-7	2
3			FINANCE		SCHEDULE						3
4			BANKING								4
5	ROSLYN INDICH	CLERICAL	CLERICAL	10.25		5.4	8.97	SALARY	4,302	21-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 20,879		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT, INC.
Street Address: 5940 W. TOUHY
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	459,177	9	$ 75,722	$ 75,722	51,951	$ 8,567	1
2	5	ELECTRICITY	CENSUS DAYS	579,760	13	4,894		51,951	439	2
3	6	MAINT & REPAIRS	CENSUS DAYS	579,760	13	11,630		51,951	1,042	3
4	6	MAINTENANCE SALARIES	CENSUS DAYS	579,760	13	120,135	120,135	51,951	10,765	4
5	10	NURSING SALARIES	CENSUS DAYS	579,760	13	379,168	379,168	51,951	33,976	5
6	10a	THERAPY SUPPLIES SERVICE	CENSUS DAYS	579,760	13	3,372		51,951	302	6
7	10a	THERAPY SALARIES	CENSUS DAYS	579,760	13	100,459	100,459	51,951	9,002	7
8	17	ADMIN. SALARIES	CENSUS DAYS	579,760	13	624,886	624,886	51,951	55,995	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	579,760	13	88,050		51,951	7,890	9
10	20	ADVERTISING	CENSUS DAYS	579,760	13	29,166		51,951	2,614	10
11	21	TOTAL OFFICE	CENSUS DAYS	579,760	13	243,348		51,951	21,806	11
12	21	CLERICAL SALARIES	CENSUS DAYS	579,760	13	726,859	726,859	51,951	65,132	12
13	23	SEMINARS	CENSUS DAYS	579,760	13	11,834		51,951	1,060	13
14	24	TRAVEL	CENSUS DAYS	579,760	13	4,741		51,951	425	14
15	25	TRANSPORTATION	CENSUS DAYS	579,760	13	33,425		51,951	2,995	15
16	26	INSURANCE	CENSUS DAYS	579,760	13	50,288		51,951	4,506	16
17	27	EMPLOYEE BENEFITS	CENSUS DAYS	579,760	13	464,414		51,951	41,615	17
18	30	DEPRECIATION (SL)	CENSUS DAYS	579,760	13	158,032		51,951	14,161	18
19	32	INTEREST	CENSUS DAYS	579,760	13	387,734		51,951	34,744	19
20	34	OFFICE RENT	CENSUS DAYS	579,760	13	99,626		51,951	8,927	20
21	35	EQUIPMENT RENT	CENSUS DAYS	579,760	13	92,291		51,951	8,270	21
22										22
23										23
24										24
25	TOTALS					$ 3,710,074	$ 2,027,229		$ 334,233	25

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: AVENUE ASSOCIATES, LLC
Street Address: 5940 W. TOUHY
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	SL DEPRECIATION	DIRECT COST	1	1	$	$	1	$	1
2	32	INTEREST	DIRECT COST	1	1			1		2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY: AVENUE ASSOCIATES LLC						$	$			$	1
2	PACIFIC MUTUAL		X	MORTGAGE	$38,703.00	12/95	4,657,452	4,166,273	01/08	0.0888	374,356	2
3	LOAN COST		X	LOAN COST	W/O OVER 12 YEARS		118,077	48,429	01/08		9,840	3
4	CIB BANK		X	CAPITAL IMPROVEMENTS	$6,635.09	02/01	315,000	209,093	02/06	PRIME+	19,673	4
5	LOAN COST		X	LOAN COST	W/O OVER 5 YEARS		1,575	997	02/06		315	5
	Working Capital											
6	CAREPLUS MGMT INC.	X		WORKING CAPITAL	DEMAND		750,000	(1,585,000)		PRIME+	(104,336)	6
7	IMPERIAL A .I .CREDIT		X	INSURANCE FINANCING							4,627	7
8	CAREPLUS MGMT ALLOCATION										34,744	8
9	TOTAL Facility Related				$45,338.09		$ 5,842,104	$ 2,839,792			$ 339,219	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES							97	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 97	14
15	TOTALS (line 9+line14)						$ 5,842,104	$ 2,839,792			$ 339,316	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 163,770	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 166,364	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,594	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 168,028	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 170,622	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	155,823	8
	1998	158,589	9
	1999	157,524	10
	2000	162,147	11
	2001	166,364	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME AVENUE CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0033340

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-02-312-001-0000	NURSING HOME	$ 166,364.00	$ 166,364.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 166,364.00	$ 166,364.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,293 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	51,736	1995	$ 100,000	1
2					2
3	TOTALS	51,736		$ 100,000	3

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155		1995	1971	$ 4,046,250	$ 103,746	39	$ 103,746	$	$ 817,141	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SPRINKLER SYSTEM			1988	5,400	171	25	216	45	3,150	9
10	LEASEHOLD IMPROVEMENTS			1989	1,035	33	20	52	19	676	10
11	LEASEHOLD IMPROVEMENTS			1990	5,400	171	20	270	99	3,397	11
12	LEASEHOLD IMPROVEMENTS			1991	14,414	457	20	721	264	8,292	12
13	LEASEHOLD IMPROVEMENTS			1992	42,003	1,384	31.5	1,333	(51)	14,322	13
14	LEASEHOLD IMPROVEMENTS			1993	16,403	433	31.5	521	88	4,949	14
15	LEASEHOLD IMPROVEMENTS			1993	1,081	72	15	72		684	15
16	LEASEHOLD IMPROVEMENTS			1994	15,686	402	39	402		3,485	16
17	LEASEHOLD IMPROVEMENTS			1994	9,604		20	480	480	4,080	17
18	ELEVATOR REPAIR & DOOR			1995	44,614	1,144	39	1,144		8,342	18
19	PAVING			1995	3,600	240	15	240		1,800	19
20	ALARM SYSTEM			1996	1,820	47	39	47		315	20
21	PLUMBING			1996	2,737	70	39	70		464	21
22	WALK-IN COOLER			1996	9,998	256	39	256		1,607	22
23	DOORS AND ROOF REPAIR			1997	5,110	131	39	131		766	23
24	FENCE			1997	19,800	508	39	508		2,815	24
25	FLOORING/BUMPER GUARDRAILS/HANDRAILS			1997	30,579	785	39	785		4,229	25
26	BUILT-IN NURSES' STATION & WARDROBES			1997	26,176	671	39	671		3,692	26
27	SMOKE & FIRE DAMPERS			1998	7,100	182	39	182		765	27
28	ELEVATOR REPAIR AND LAUNDRY ROOM ELECTRICAL/CIRCU			1998	5,931	152	39	152		706	28
29	PARKING LOT PAVING AND LANDSCAPING			1998	53,109	3,680	15	3,680		16,072	29
30	FLOORING			1998	11,516	295	39	295		1,316	30
31	FIRE SAFETY UPGRADE/LIGHTING/EXHAUST/ROOF			1999	57,028	1,462	39	1,462		5,177	31
32	ONE SUMP PUMP ASSEMBLY			2000	4,200	153	27.5	153		325	32
33	RELOCATION OF A/C UNIT			2000	3,015	110	27.5	110		234	33
34	INSTALL PULL STATION & REWIRE BLDG			2000	5,878	214	27.5	214		455	34
35	CONCRETE STAIRS & RAMP REPLACEMENT			2001	20,000	727	27.5	727		1,121	35
36	REPLACEMENT CARPET-1ST FLOOR			2001	2,422	775	20	121	(654)	242	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LANDSCAPE INSTALLATION	2001	$ 2,910	$ 276	15	$ 276	$	$ 470	37
38	REPAIR PASSENGER & SMALL SERVICE ELEVATORS	2001	11,654	424	27.5	424		548	38
39	DECK	2001	12,170	1,156	15	1,156		1,967	39
40	SECOND FLOOR RESIDENT ROOMS-CLOSETS	2001	26,075	948	27.5	948		1,146	40
41	REPLACE PUMP MOTOR ON THE PASSENGER ELEVATOR	2002	2,580	90	27.5	90		90	41
42	BATHROOMS - INSTALLATION OF NEW SHEET VINYL	2002	1,297	2	27.5	2		2	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50	CAREPLUS MANAGEMENT, INC:								50
51	LEASEHOLD IMPROVEMENTS			106		106			51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,528,595	$ 121,473		$ 121,763	$ 290	$ 914,842	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 211,771	$ 15,663	$ 17,086	$ 1,423	5-10	$ 131,694	71
72	Current Year Purchases	32,049	12,476	1,827	(10,649)	5-10	1,827	72
73	Fully Depreciated Assets	24,768						73
74	RELATED PARTY-ALLOCATION		20,966	20,966				74
75	TOTALS	$ 243,820	$ 49,105	$ 39,879	$ (9,226)		$ 133,521	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,872,415	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 170,578	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 161,642	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (8,936)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,048,363	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 35,260 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 32,584	$		$ 32,584	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			75,287			75,287	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				50,459		50,459	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES Other (specify): LAB/RENTALS	39-2 39-2					300 2,055		300 2,055	13
14	TOTAL			$		$ 107,871	$ 52,814		$ 160,685	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number AVENUE CARE CENTER # 0033340 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 86,241	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 135,000)	1,443,835		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,161		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	122,361		8
9	Other(specify): Real Estate Tax Escrow	(78,810)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,618,788	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	472,741		15
16	Equipment, at Historical Cost	253,424		16
17	Accumulated Depreciation (book methods)	(297,865)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	115,552		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 543,852	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,162,640	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 440,608	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,736		28
29	Short-Term Notes Payable	(1,543,659)		29
30	Accrued Salaries Payable	83,836		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,384		31
32	Accrued Real Estate Taxes(Sch.IX-B)	168,028		32
33	Accrued Interest Payable	1,590		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (799,477)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (799,477)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,962,117	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,162,640	$	48

***(See instructions.)**

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,622,030	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	(48,840)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,573,190	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	815,177	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(426,250)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 388,927	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,962,117	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,749,933	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,749,933	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	133	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 133	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	400	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 400	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,750,466	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	761,946	31
32	Health Care	1,819,493	32
33	General Administration	1,389,877	33
	B. Capital Expense		
34	Ownership	702,948	34
	C. Ancillary Expense		
35	Special Cost Centers	160,685	35
36	Provider Participation Fee	84,863	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,919,812	40
41	**Income before Income Taxes (line 30 minus line 40)****	830,654	41
42	**Income Taxes**	(15,477)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 815,177	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. TAX RETURN CASH BASIS**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,001	2,184	$ 66,256	$ 30.34	1
2	Assistant Director of Nursing	1,775	1,907	46,382	24.32	2
3	Registered Nurses	6,959	7,209	152,238	21.12	3
4	Licensed Practical Nurses	22,605	23,371	424,607	18.17	4
5	Nurse Aides & Orderlies	68,392	72,056	577,050	8.01	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,458	9,163	80,711	8.81	8
9	Activity Director	1,400	1,471	15,295	10.40	9
10	Activity Assistants	8,435	9,500	68,646	7.23	10
11	Social Service Workers	7,432	7,747	131,128	16.93	11
12	Dietician					12
13	Food Service Supervisor	2,033	2,085	21,501	10.31	13
14	Head Cook	5,311	5,497	37,191	6.77	14
15	Cook Helpers/Assistants	11,725	12,478	83,236	6.67	15
16	Dishwashers					16
17	Maintenance Workers	3,870	4,125	36,819	8.93	17
18	Housekeepers	15,377	16,675	116,919	7.01	18
19	Laundry	5,919	6,363	48,958	7.69	19
20	Administrator	1,946	2,080	86,518	41.60	20
21	Assistant Administrator	2,064	2,213	45,042	20.35	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,566	2,637	22,277	8.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,529	1,610	12,522	7.78	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	179,797	190,371	$ 2,073,296 *	$ 10.89	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 6,600	1-3	35
36	Medical Director	O	5,500	9-3	36
37	Medical Records Consultant	N	52,448	10-3	37
38	Nurse Consultant	T	50,000	10-3	38
39	Pharmacist Consultant	H	555	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,875	11-3	44
45	Social Service Consultant	E	3,806	12-3	45
46	Other(specify) PSYCHIATRIC	S	25,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 156,584		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides		N/A	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
GLORIA GREEN	ADMIN	0	$ 23,495
SAM BIBER	ADMIN	0	62,983
MARK GAMBLE	ASST ADMIN	0	45,082
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 131,560

B. Administrative - Other

Description		Amount
CAREPLUS MGMT	MANAGEMENT FEES	$ 330,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 330,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
CAREPLUS MGMT	DATA PROCESSING	$ 12,000
HDSI	DATA PROCESSING	1,240
AMERICAN DATA	DATA PROCESSING	2,437
NATIONAL DATACARE	DATA PROCESSING	1,265
CAREPLUS MGMT	ADMIN. CONSULT	218,000
KBKB	ACCOUNTING FEES	28,550
MEYER MAGENCE	LEGAL FEES	4,192
WINSTON & STRAWN	LEGAL FEES	642
ART ROUSEAU	LEGAL FEES	150
ECONOCARE	PURCHASE CONSULT	2,790
PERSONNEL PLANNERS	UC CONSULT	2,044
RICHARD PEELO	MEDICARE CONSULT	3,750
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 277,060

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,612
Unemployment Compensation Insurance	29,333
FICA Taxes	157,533
Employee Health Insurance	80,381
Employee Meals	15,275
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,340
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	21,984
CHICAGO HEAD TAX	3,712
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 340,170

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	14,569
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	2,481
TRUST/FRANCHISE/CONTRIB/ETC	400
LICENSES & PERMITS	1,150
DUES & SUBSCRIPTIONS	10,170
MGMT CO ALLOCATION	2,614
TRUST/FRANCHISE/CONTRIB/ETC	(400)
Less: Public Relations Expense	(0)
Non-allowable advertising	(1,352)
Yellow page advertising	(1,129)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,703

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOCATION	425
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 0

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9								N/A					
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. **IL COUCIL LONG TERM CARE $8370**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **409** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **84,863**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **15,275** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: AVENUE CARE CENTER **#0033340** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,600	
	REPAIRS & MAINTENANCE		6,307	
			0	12,907
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		38,667	
	ELECTRICITY		42,740	
	WATER		26,749	
	CABLE TV - LOBBY		1,458	
			0	109,614
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,490	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		11,455	
	ELEVATOR MAINTENANCE & REPAIR		7,373	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		5,400	
	FIRE SERVICE		4,543	
			0	
			0	
			0	30,261
7	**OTHER**			
	SCAVENGER		10,289	
	SECURITY SERVICE		0	10,289
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	5,500	5,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		82	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	52,448	
	PHARMACY CONSULTANT	XVIII B 39-2	555	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	25,000	
	RN CONSULTANT	XVIII B 38-2	50,000	
			0	
			0	128,085
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		6,737	
	SPEECH THERAPY SERVICES		756	
	OCCUPATIONAL THERAPY SERVICES		5,954	
	THERAPY CONTRACT SERVICE	XVIII B __-2	15,650	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	5,400	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,400	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	39,897
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,875	
			0	1,875
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,806	
			0	3,806
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number AVENUE CARE CENTER **#0033340** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		145	145
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	330,000	330,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	16,942	
	ADMINISTRATIVE CONSULTANTS	XIX C	218,000	
	PROFESSIONAL FEES	XIX C	42,118	
			0	277,060
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	1,352	
	EMPLOYEE WANT ADS	XIX F	14,569	
	CONTRIBUTIONS	VI 20 XIX F	400	
	DUES & SUBSCRIPTIONS	XIX F	10,170	
	LICENSES & PERMITS	XIX F	1,350	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,129	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	28,970
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		7,423	
	OUTSIDE CLERICAL SERVICES		93,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	16,499	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		18,278	
	MESSENGER SERVICE		645	
	SETTLEMENT - LEGAL		2,000	137,845

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	157,533	
	UNEMPLOYMENT COMPENSATION	XIX D	29,333	
	WORKERS COMPENSATION INSURANC	XIX D	29,612	
	HOSPITALIZATION INSURANCE	XIX D	80,381	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,340	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	UNION PENSION FUND/401 K EXPENSE	XIX D	21,984	
	CHICAGO HEAD TAX	XIX D	3,712	324,895
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,310	2,310
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		204	204
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		123,561	123,561
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,567,224

AVENUE CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	161,623
LESS SALES TAX	(736)
NET FOOD	160,887
TOTAL PATIENT CENSUS	51,951
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	155853
ADD # EMPLOYEE MEALS/DAY	45
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	16425

PATIENT MEALS	155853
ADD EMPLOYEE MEALS	16425
TOTAL MEALS/YEAR	172278
NET FOOD	160887
DIVIDE TOTAL MEALS/YEAR	172278
COST PER MEAL	0.93
TIME EMPLOYEE MEALS	16425
EMPLOYEE MEAL RECLASSIFICATION	15275